ERRATA

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: ELIGIBILITY AND GRANT FORMS TO IMPLEMENT THE CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) PROGRAM

REFERENCE: ALL COUNTY INFORMATION NOTICE (ACIN) I-70-97;
ALL COUNTY LETTER (ACL) 97-68

This Errata transmits corrected copies of the SAWS 2, Statement of Facts; SAWS 2A, Rights and Responsibilities form; and CW 40, CalWORKs Reduced Income Supplemental Payment Request (RISP). These corrected copies replace those transmitted in ACIN I-70-97. Camera-ready copies were not released nor was stock printed containing these errors. Printing of the CW 40 is not expected to be impacted by these corrections and is still expected for December 10. However, because of the delay in making these corrections, stock of the SAWS 1, SAWS 2 and SAWS 2A is now anticipated for December 18, 1997. We regret any inconvenience this may have caused. For your convenience, we have identified the major changes for each form below.

SAWS 1

- On Page 1, second column of the Coversheet, the term "CalWorks" was corrected to "CalWORKs" in the "MEDI-CAL PRESUMPTIVE ELIGIBILITY" section. To be consistent with ACL 97-68, the term "diversion" was corrected to "Diversion" in Item 9 on the SAWS 1.

SAWS 2

- Page 1, County Use Only (CUO) Section at the bottom of the page:
  - Column 1, Item 15, the regulation cite is revised to "408.1, .2."
  - Column 2, Item c is revised to "Mandatory participant in GAIN or Welfare to Work Activities"; Item e is revised to "Applied for or receipt of UIB"; Item h is revised to "1/2 time student in school, training or higher education."
  - Column 3, the regulation cite in the "FS [FOOD STAMP] ABAWD EXEMPTIONS" is revised to "(63-407.3)"; Item 1 is revised to add Exemption code "c"; Item 29 is changed to "Under 18/50 and Older"; Item 4 is revised to "Adult living in HH [household] with dependent child."
- Page 2, Item 3: The instruction narrative for Medi-Cal that was inadvertently deleted from the form has been reinserted.
- Page 5, Item 20 and corresponding CUO section: Narrative is revised to show that the client choices for the figuring of self-employment business expenses are for the cash aid program only, not for food stamps.
- Page 9, Item 34B: Time frames for Medi-Cal are revised from "3 years (36 months)" to "2 1/2 years (30 Months)" to parallel the new time frames for Medi-Cal in 34A.
- Page 12, Items 46 and 47A and B: typographical errors involving the "YES/NO" checkboxes are corrected. Item 46B is revised to request the "DATE CRIME COMMITTED" and to delete the request for information on a second family member.

- Page 13, column 1, third bullet: narrative is revised to add "...six months, twelve months..." to the penalty timeframes for Intentional Program Violations.
- Remaining corrections involved multiple typographical/format errors. These corrections will not be Itemized here.

SAWS 2A

- To be consistent with ACL 97-68, the term "diversion" was corrected to "Diversion" in Item 24 on the SAWS 2. New Item 39 is added for food stamp non-monthly reporting households; this option was inadvertently dropped from the form.
- Page 4, Item 27 is updated to delete "of $25 or more" from sentence one and to streamline the narrative in the second sentence.
- Page 6, column 1, narrative is added regarding specific "Welfare-to-Work Activities"; and the second column receives a header "Cash Aid Only" and a new section, "Community Service Activities" is inserted.
- Page 7:
  - Narrative is added in the first column under "CASH AID ONLY" regarding the 60-Month Time Limits.
  - The last Item, "Voter Registration" in the second column: The last sentence was inadvertently dropped off the page.
- Remaining corrections involved multiple typographical/format errors. These corrections will not be Itemized here.

CW 40

- Narrative in column 1, Item 4: Narrative in the third sentence is changed from "List expected income and expenses..." to "List expected income and source of income..." In the subset chart below, the title of the second column is changed from "Source" to "Source of Income."

COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (CMSP)

TO APPLY FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/STATE CMSP, complete Items 1-13 on the attached application, and sign the Certification Section (Item 19). Give the form to the welfare office. If you have a disability and need help applying for or continuing to receive cash aid, benefits, and services, tell the county.

BEFORE YOU CAN GET CASH AID, SUCH AS HOMELESS ASSISTANCE OR IMMEDIATE NEED; FOOD STAMPS, INCLUDING EXPEDITED SERVICE; OR MEDI-CAL/STATE CMSP you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. We use the facts you give us to figure eligibility and benefits.

TO GET CALWORKS IMMEDIATE NEED AND/OR CALWORKS HOMELESS ASSISTANCE, you must appear to be eligible for CalWORKs. Complete the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your Social Security Number(s), trying to get income available to you, and agreeing to cooperate with the district attorney about child, spousal, and medical support.

FOR FOOD STAMPS, the application can be filled in and signed under penalty of perjury by either an adult household member or by an authorized representative. If you are not an adult member of the household, you must have a written note signed by the head of household or another household member saying that you can apply for the household, pick up their food stamps, and/or use the food stamps to buy food for the household.

CALWORKS IMMEDIATE NEED

If you have an emergency, you may be able to get up to $200 while we work on your application. You will need to tell us about your emergency situation and you will need to show that you don't have the income or money to pay for these emergencies:

- Lack of housing or lack of food
- Eviction notice
- No utilities or utility shut-off notice
- Lack of essential clothing
- Essential transportation needs not met
- Other kinds of emergencies important to health and safety.

If your Immediate Need request is turned down, you can ask for it again during the time we work on your application. Let the county know if something changes.

CALWORKS HOMELESS ASSISTANCE

If you are homeless, and want to apply for homeless assistance, tell the county. Homeless Assistance is available once in a lifetime, with exceptions.

CALWORKS DIVERSION PAYMENT/SERVICES

The Diversion program helps applicant(s) who need some assistance but do not want or need to go on welfare. The Diversion program allows you to choose to get a lump sum cash payment or non-cash services instead of going on aid. You can only choose to get a Diversion payment or services at time of application for cash aid. You may be eligible for Medi-Cal, child care assistance, and food stamps.

After you have applied for cash aid, the county will tell you if you would be eligible for the Diversion program.

- If you choose to get a Diversion payment or services instead of cash aid, you will get a denial notice for cash aid and an approval notice for the Diversion program.
- Your cash aid may be lowered or the amount of time you can get cash aid may be reduced if you go on aid later.

APPLICANTS FOR FOOD STAMPS: All you have to do the day you apply is give us your name and address, tell us you want food stamps (Item 8) and sign the application (Item 19). Before we can tell if you are eligible, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. You should be told if you are eligible within 30 days after you apply.

FOOD STAMPS — Date of Eligibility

If you are eligible for food stamps, we will figure your benefits from the date you apply. You can apply for food stamps the first day you contact the welfare office.

FOOD STAMP EXPEDITED SERVICE

You may have the right to get food stamps within three days. Your household must be eligible for the Food Stamp Program AND HAVE

- rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions **(see the other side of the page for definitions of income and liquid resources),**

OR

- no more than $100 liquid resources and less than $150 income for the month before deductions,

OR

- no more than $100 liquid resources and at least one member who is a migrant or seasonal farmworker.

Before you can get food stamps within three days, **complete Items 1 - 17 on the attached application**; give us all the facts we ask for during your eligibility interview; and give us proof of your identity.

MEDI-CAL PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

If you are pregnant, you may get temporary Medi-Cal from certain medical providers for many prenatal care services before applying for regular Medi-Cal. Ask your doctor or clinic if they offer PE. If you apply for CalWORKs or Medi-Cal by the end of the month after the month you get a PE card, your temporary Medi-Cal will continue until aid is approved or denied. If you are getting PE, check "YES" in both parts of Item 12 and tell the county.

MEDI-CAL/STATE CMSP - MEDICAL EMERGENCY/ PREGNANCY

If you have a medical emergency or are pregnant AND want Medi-Cal as soon as possible, complete Items 1-14. You must also give all the facts we ask for during your eligibility interview and meet all eligibility requirements.

WHAT WE MEAN WHEN WE SAY:

- **Cash Aid:** CalWORKs (California Welfare Opportunity and Responsibility To Kids) and Refugee Cash Assistance.
- **Diversion:** A lump sum cash payment or non-cash services instead of going on cash aid.
- **Food Stamps:** benefits for low income households to help buy food.
- **Food Stamp Expedited Service:** food stamps within 3 days.
- **Medi-Cal:** medically necessary benefits for eligible persons.
- **Medi-Cal Presumptive Eligibility (PE):** temporary Medi-Cal coverage from certain doctors or clinics for many out-patient prenatal care services.
- **Restricted Medi-Cal:** emergency and pregnancy related care only.
- **Authorized Representative:** a person picked by an applicant or recipient for food stamps and/or Medi-Cal, who can take care of some of their business.
- **Head of Household:** a responsible member of the food stamp household.
- **Income:** money received or expected, such as:
  - earnings, welfare, child support, Supplemental Security Income/State Supplementary Program (SSI/SSP) or Social Security, pension or retirement payments;
  - Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI), Veterans Benefits (VA), or other disability payments;
  - strike funds; payments from roomers and boarders; school grants and loans;
  - cash gifts, cash winnings, any other cash payments.
- **Liquid Resources:** other money, such as:
  - cash on hand, uncashed checks; money in checking accounts, savings accounts; or saving certificates;
  - trust deeds, notes receivable, stocks or bonds, etc.
- **State CMSP**: Medically necessary benefits for eligible adults who are not on Medi-Cal and who live in some rural counties.
- **Restricted State CMSP**: Emergency care only.
- **Utilities:** gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.
- **You, Anyone, Everyone:** any and all persons who live in your home.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for cash aid and food stamps at the same time and have one interview for both.
- You have the right to fill out this form yourself or, if you ask, have someone help you.
- **FRAUD AND PERJURY:** Fraud and perjury are crimes. The law says you must sign a penalty of perjury statement on most forms to get and to keep getting cash aid, food stamps, and Medi-Cal. Perjury means that you swear under oath to give true, correct and complete facts. If you lie about facts or **on purpose** do not give us all the facts or situations that affect your eligibility and aid payment levels, you can be charged with fraud.
- **If you are found guilty of committing fraud, you may be fined up to $10,000 for cash aid and $250,000 for food stamps and/or sent to jail/prison for 3 years for cash aid and 20 years for food stamps. Cash aid and/or food stamps can be stopped for six months, twelve months, two years, four years, five years or forever.**
- **OVERPAYMENTS/OVERISSUANCES** – means you got more aid or benefits than you should have gotten. You will have to pay it back and your cash aid or food stamps will be lowered or stopped. Your Medi-Cal/CMSP share of cost may be changed.
- **SOCIAL SECURITY NUMBER (SSN) RULES** - We computer match SSNs against records from tax, welfare, employment, the Social Security Administration and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also match SSNs to be sure that you aren't getting aid in more than one case, or in another county or state.

  Cash aid and food stamps: You must give us the SSN for each applicant/recipient for cash aid and/or food stamps. If you refuse to give us either the SSN or proof of application for the SSN, you won't be able to get cash aid or food stamps. For cash aid, you must give us your SSN(s) or proof of application for the SSN within 30 days of application and give the SSN to the county when you get it.

  Medi-Cal: Each applicant for Medi-Cal who has an SSN is asked to give it to the county. Any U.S. citizen, U.S. national, amnesty alien with a valid and current I-688, alien with lawful permanent residence in the U.S. (LPR), or alien permanently residing in the U.S. under color of law (PRUCOL) who refuses to give an SSN or proof of application for an SSN, will not be able to get Medi-Cal/State CMSP. Any alien who does not have an SSN and who is not an amnesty alien with a valid and current I-688 or an LPR or PRUCOL, can still get restricted Medi-Cal/State CMSP if he/she meets all eligibility rules, including California residency.

COMPLAINTS

If you think you have been discriminated against, contact your county's civil right's representative or write to:
State Civil Rights Bureau
P.O. Box 944243
Sacramento, CA 94244-2430
or by calling collect (916) 654-2107
or for the hearing impaired TDD
1-(800) 654-2098

For other kinds of complaints, contact your county first. If you and the county can't agree, write or call to:
Public Inquiry and Response (PIAR)
744 P Street, M.S. 16-23
Sacramento, CA 95814
Phone 1 - (800) 952 - 5253
or for the hearing impaired
TDD 1 - (800) 952-8349

STATE HEARINGS

You can ask for a State Hearing by writing to your local county welfare office or by calling one of the phone numbers listed for PIAR above, if:

- you do not agree with any action taken by the county, or
- you are asking for a state hearing for cash aid, food stamps, Medi-Cal, or
- you think you are not getting the right State CMSP service.

To appeal all State CMSP eligibility issues, you can **only write** to your county. You must ask for the hearing within 90 days of the county's action and you must tell why you want a hearing.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL /STATE CMSP (CW 1)

Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)

2. SOCIAL SECURITY NUMBER (SSN)

3. MAIDEN OR OTHER NAME (IF ANY)

4. HOME ADDRESS: NUMBER STREET
CITY ZIP CODE

5. MAILING ADDRESS (IF DIFFERENT)
CITY ZIP CODE

6. TELEPHONE NUMBER(S): HOME WORK MESSAGE

7. Is your home address permanent? ☐ YES ☐ NO ☐ NO HOME
If not permanent, please explain:

8. Is anyone applying for: Cash Aid ☐ YES ☐ NO Medi-Cal ☐ YES ☐ NO
Food Stamps ☐ YES ☐ NO State CMSP ☐ YES ☐ NO
Any Other Program(s) ☐ YES ☐ NO If YES, explain:

9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/Medicaid or Diversion payment or services from the county? If YES, list: Name(s) used, where (county, state, country), when, type(s) of aid or benefit: ☐ YES ☐ NO

10. The law says we must record your ethnic group and language. This won't affect your eligibility.
a. Ethnic Group
☐ White ☐ Hispanic ☐ Black ☐ Filipino ☐ Guamanian
☐ Asian Indian ☐ Alaskan Native ☐ American Indian
☐ Laotian ☐ Cambodian ☐ Japanese ☐ Korean ☐ Chinese ☐ Samoan
☐ Vietnamese ☐ Hawaiian ☐ Other Asian or Pacific Islander (Specify):

b. Language
☐ English ☐ Cantonese ☐ Lao ☐ Tagalog ☐ American Sign
☐ Spanish ☐ Cambodian ☐ Vietnamese ☐ Russian ☐ Other (Specify):

11. Is anyone a migrant or seasonal farmworker? ☐ YES ☐ NO

12. Is anyone pregnant? ☐ YES ☐ NO If YES, did she get a Presumptive Eligibility card? ☐ YES ☐ NO

13. Does anyone have a personal emergency? If YES, check (✔) type: ☐ YES ☐ NO
☐ Immediate Medical Need ☐ Pregnancy ☐ Child Abuse ☐ Spousal Abuse
☐ Elder Abuse ☐ Other emergency which threatens health or safety: Explain:

IF YOU NEED: CALWORKS IMMEDIATE NEED PAYMENT .....FILL IN ITEMS 14 - 18.
FOOD STAMP EXPEDITED SERVICE .....FILL IN ITEMS 14 - 17.
MEDI-CAL OR ARE PREGNANT AND HAVE AN IMMEDIATE MEDICAL NEED .....FILL IN ITEM 14.

14. How much liquid resources does everyone, including children, have?
☐ Cash, uncashed checks or money orders $_____
☐ Checking/savings or credit union account(s) $_____
☐ Trust deeds, notes receivable, stocks or bonds $_____
☐ Other (explain) $_____

15. How much income did everyone, including children, get or will they get this month?

Date	Amount	Date	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____

16. How much is your rent or mortgage this month?
$ _____

17. How much are your utilities that are not included in your rent this month? $_____

18.
- Do you have an eviction notice or notice to pay or quit? ☐ YES ☐ NO
- Have your utilities been shut off or do you have a shut-off notice? ☐ YES ☐ NO
- Will your food run out in 3 days or less? ☐ YES ☐ NO
- Do you need essential clothing, such as diapers or clothing needed for cold weather? ☐ YES ☐ NO
- Do you need help with transportation to get food, clothing, medical care or other emergency item(s)? ☐ YES ☐ NO

- I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified.
- I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service.
- **I declare under penalty of perjury under the laws of the United States of America and the State of California that information I have given on this form is true, correct, and complete.**

19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE DATE SIGNED

SIGNATURE OF WITNESS TO MARK OR INTERPRETER DATE SIGNED

COUNTY USE ONLY

CASE NAME

CASE NUMBER

DATE RECEIVED

TYPE OF APPLICATION:
CA: ☐ CA ☐ RCA
FS: ☐ Initial ☐ Recert ☐ Rest
MC: ☐ **CMSP:** ☐

Homeless:
FS: ☐ YES ☐ NO
CA: ☐ YES ☐ NO ☐ CA 42

☐ Pickle Screening
☐ Diversion

Ethnic Group:

Primary Language:

☐ Presumptive Eligibility input
☐ **Referral Date:**

CA IN
☐ Denied/NOA prep
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete
(_____)
(Initials)

FS E.S.
☐ E.S. questions not completed
☐ Screened for E.S.
Date_____
(_____)
(Initials)

FS Referral for:
☐ E.S. Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

☐ Copy of CW 1 and coversheet given to applicant

COUNTY OF APPLICATION

COUNTY OF RESIDENCE (IF DIFF)

RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

For the Cash Aid and Food Stamp Programs, and/or Medi-Cal/State–Run County Medical Services Program (CMSP)

These pages give you your rights and responsibilities and other important information. The county needs your facts to see if you are eligible for cash aid, food stamps, and/or Medi-Cal/State CMSP and to figure how much you will get if you are eligible. If you need more information or have questions, ask your worker.

Cash Aid includes California Work Opportunity and Responsibility to Kids (CalWORKs) and Refugee Cash Assistance (RCA).

Medi-Cal/State CMSP includes Full Medi-Cal/State CMSP benefits and Restricted Medi-Cal/CMSP emergency and pregnancy related care only.

YOUR RIGHTS

1. To be treated equally without regard to race, color, national origin, religion, political affiliation, marital status, sex, disability, or age. You may file a complaint of discrimination if you feel you have been discriminated against by first speaking with your county's designated civil rights representative or by writing to the

   State Civil Rights Bureau
   744 P Street, MS 15-70
   P.O. Box 944243
   Sacramento, CA 94244-2430

   or by calling **collect** (916) 654-2107 or for the hearing impaired TDD (916)-654-2098.
2. To tell the county if you have a disability and need help applying for or continuing to receive cash aid, benefits, and services.
3. To ask for help to complete your application for any other cash aid, food stamp, or Medi-Cal/State CMSP form.
4. To ask for forms and notices to be translated if you don't read English.
5. To be treated with courtesy, consideration and respect.
6. To be interviewed promptly by the county when you apply and to have your eligibility determined within 45 days for cash aid and Medi-Cal/State CMSP (or 90 days for Medi-Cal if a determination of disability is required) and within 30 days for food stamps.
7. To discuss your case with the county and to review your case yourself when you request to do so.
8. To be told the rules for getting cash aid right away. If we think you might be eligible, you will get an interview within one day.
9. To be told the rules for getting food stamps right away. If we think you might be eligible to get them right away, you will get an interview immediately and get food stamps within three days.
10. To get Medi-Cal/State CMSP as soon as possible if you have a medical emergency or are pregnant, if eligible.
11. To continue getting cash aid and Medi-Cal benefits without a break if you move from one county to another if you stay eligible.
12. To be told the rules for retroactive Medi-Cal/State CMSP eligibility.
13. To lower any current Share of Cost you may have by giving the county past unpaid medical bills you still owe, when you apply for Medi-Cal/State CMSP.
14. To choose prepaid health plan (PHP), fee-for-service coverage (if available), Health Maintenance Organization (HMO), or Medi-Cal when eligible for Medi-Cal/State CMSP.
15. To ask to have your Food Stamp I.D. or Medi-Cal Benefits Identification Card (BIC), Food Stamp authorization document or issuance card, or Food Stamp coupons replaced if lost in the mail, damaged, or destroyed. The county will tell you if you are eligible. Your BIC may also be replaced if lost or stolen.
16. To ask for extra money if your income drops or stops (cash aid only).
17. To ask for payments for clothing, housing or essential household items which are lost, damaged or otherwise unavailable due to sudden and unusual circumstances (cash aid only).
18. To ask for payments for ongoing special needs like a special diet, transportation for ongoing medical care, special laundry service, telephone for the hard of hearing, high utility bills, etc. (cash aid only).
19. To be notified in writing when your application is approved, denied, or when your benefits change or stop.
20. To have your records kept confidential by the county and state, unless you are getting cash aid or food stamps and there is a felony arrest warrant issued for you, or as otherwise provided by law.
21. To talk with someone from the county or file a formal complaint with the state if you don't agree with an action taken by the county. You may call toll-free at 1-800-952-5253 or for the hearing impaired, TDD 1-800-952-8349.
22. To ask for a State Hearing within 90 days of the county's action for cash aid, food stamps, Medi-Cal, and, if you think you were not getting the right State CMSP services.
23. To ask for a State Hearing, you can write to your county or call the State toll-free telephone numbers listed in Item 20 above.
24. To appeal all State CMSP eligibility issues, you can **only write** to your county.
25. To be represented at a State hearing by yourself, a household member, friend, attorney, or other person of your choice. NOTE: You may get free legal help at your local legal aid office or welfare rights group.

YOUR RESPONSIBILITIES

Citizenship/Immigration Status

To sign under penalty of perjury that each member applying for cash aid and food stamps is a U.S. citizen, U.S. national or has lawful immigration status. Information you give us on immigration status will be checked with the U.S. Immigration and Naturalization Service (INS). Information we get from INS may affect your eligibility.

If you want Medi-Cal/State CMSP, you must provide a declaration of citizenship/immigration status under penalty of perjury. If you say you are an alien with lawful permanent residence (LPR) in the U.S., an amnesty alien with a valid and current I-688 or an alien permanently residing under color of law (PRUCOL), your immigration status will be checked with the U.S. Immigration and Naturalization Service (INS). The information the INS receives to verify the immigration status of the applicant can only be used to determine Medi-Cal/State CMSP eligibility, and cannot be used for immigration enforcement unless you are committing fraud.

Social Security Number (SSN) Rules

The SSNs will be used in a computer match to check income and resources with records from tax, welfare, employment, the Social Security Administration and other agencies. Differences may be checked out with employers, banks or others. Making false statements or failing to report all facts or situations which affect eligibility and aid payments for cash aid, food stamp and Medi-Cal/State CMSP may result in repayment of benefits and/or criminal or civil action.

Cash Aid and Food Stamps: You must give us the SSN for each applicant or recipient of cash aid and/or food stamps. If you refuse to give us either a SSN or proof of application for a SSN, you will not be able to get cash aid or food stamps. For cash aid, you must give proof of application for a SSN within 30 days of application for cash aid and give the SSN to the county when you get it.

Each applicant for Medi-Cal/State CMSP, who says he/she is a U.S. citizen, a U.S. national, LPR in the U.S., an amnesty alien with a valid and current I-688, or PRUCOL, will be disqualified from getting Medi-Cal if he/she refuses to give either a SSN or proof of application for a SSN. Any alien who does not have a SSN and who is not an amnesty alien with a valid and current I-688 or a LPR or PRUCOL, can still get restricted Medi-Cal/State CMSP if he/she meets all eligibility rules, including California residency.

Verification(s)

To give proof to support your eligibility. If you can't get proof, you will need to give the name of some other person or agency we may contact to get the proof. We will help you get proof when you can't get it.

Cooperation

To cooperate with county, state and federal staff. For cash aid, a county worker can come to your home at any time to check out your facts, including seeing each family member, without calling ahead of time. You may not get benefits or your benefits may be stopped if you don't cooperate.

FOOD STAMPS AND CASH AID

To tell the county when any member of your household:

- is hiding or running from the law for a felony, or attempted felony, or is violating their parole or probation as they will not be eligible for cash aid and/or food stamps.
- has been convicted of a drug related felony for possession, use or distribution of illegal drugs since August 22, 1996, as they may not be eligible for food stamps, or if convicted since January 1, 1998, they will not be eligible for cash aid.

CASH AID AND MEDI-CAL

To apply for any benefits or income anyone is eligible to get, such as: Unemployment (UIB) or Disability benefits, Veterans benefits, Social Security or Medicare, etc.

Child/Spousal and Medical Support

To cooperate with the county and the District Attorney/Family Support Division (DA/FSD) to:

- identify and locate any absent parent in your case;
- tell the county or the DA/FSD anytime you get information about the absent parent, such as place of residence or work location;
- determine the paternity of any child in your case when needed;
- obtain medical support money from any absent parent and, if you get cash aid, obtain child support money;
- give the DA/FSD any medical support money and, any child/spousal support money you get;
- tell the county about medical coverage or money for medical services paid by the absent parent.

Your cash aid will be lowered if you don't cooperate.

MEDI-CAL

Benefits Identification Card (BIC)

- To sign your BIC when you get it and to use it only to get necessary health care services.
- **To never throw your BIC away** (unless we give you a new BIC). You need to keep your BIC even if you stop getting Medi-Cal. You can use the same BIC if you get cash aid or Medi-Cal again.
- To take the BIC to your medical provider when you or a family member is sick or has an appointment.
- To take the BIC to the medical provider who treated you or your family member(s) in an emergency situation as soon as possible after the emergency.

Health Care Coverage/Insurance

- To tell the county and any health care provider of any health care coverage/insurance you or a family member have.
- To retain any health insurance available to you and your family at no or reasonable cost.
- To use any prepaid health plans, health maintenance organization or health care insurance plans you have before using Medi-Cal/State CMSP, unless the plan does not offer the medical service needed. You need to use them because Medi-Cal will not pay for any service paid for and/or provided by these medical insurance plans.
- To enroll and stay enrolled in an employment-related group health plan when Medi-Cal approves payment of plan premiums by the State of California.

YOUR REPORTING RESPONSIBILITIES

You must report all changes to the county. If you're not sure how to report changes, what changes to report, or what proof we need, ask your worker. If you get food stamps, your worker will tell you if you are a monthly or nonmonthly reporting household. If you get Medi-Cal/State CMSP, the county will tell you if you must report monthly or quarterly.

HOW YOU MUST REPORT

For Cash Aid, you must report all changes to the county within 5 days AND turn in a complete Monthly Eligibility Report by the 5th of each month.

For Food Stamp Monthly Reporting, you must turn in a complete Monthly Eligibility Report by the 5th of each month.

Note: If you get both cash aid and food stamps, you will need to turn in only one complete Monthly Eligibility Report by the 5th of each month.

For Food Stamp Nonmonthly Reporting, you must report all changes within 10 days:

- by mail, telephone, or in person at the County Food Stamp office; OR
- on a DFA 377.5, Food Stamp Household Change Report; OR
- if you get cash aid, you may report the change(s) on your Monthly Eligibility Report.

For Medi-Cal/State CMSP Quarterly Reporting Beneficiaries, you must report all changes within 10 days AND turn in a complete Status Report by the 5th of the month when the county sends or gives it to you.

WHEN YOU MUST REPORT

For Cash Aid, Food Stamp Monthly Reporting, and Medi-Cal/State CMSP, you must report when:

1. Anyone gets money (including lump sums) from work, relatives, Social Security, Unemployment Insurance Benefits (UIB), Veterans benefits, tax refunds, or any other source.
2. Anyone gets child, spousal, or medical support money.
3. Anyone's job or training program changes.
4. Anyone's income or source of income changes, starts, or stops, including self-employment.
5. Anyone age 16 or older starts or stops school, college, or training. For Food Stamps Only, any child up to age 17 or any adult who starts or stops school or training.
6. You move in with someone else or anyone moves into or out of your home, including newborns, other children, spouses, absent parents, other relatives, and non-relatives.
7. Anyone (including children) comes into the home, leaves the home, or plans to visit somewhere else even for a short period of time (cash aid only).
8. Anyone moves to another address, plans to move (including out of state), or gets a new mailing address. If you move to another county and you want to keep getting benefits, you must tell the county giving you aid and/or benefits AND ask for cash aid, food stamps, or Medi-Cal in the new county. You must also ask for State CMSP, if it is available in the new county.
9. Any changes in rent or utility costs when there is a move or when anyone gets free rent/utilities.
10. Anyone gets payments or allowances for job, training, or school expenses, such as educational grants and loans, transportation to and from job or training, etc.
11. Anyone has job, training, or school costs, such as dependent care, transportation, tuition, books, etc.
12. Anyone has expenses that are paid for by someone else in total or in part, such as housing, utilities, dependent care, etc.
13. Anyone gets married, separated, divorced, or died.
14. Anyone gets, sells, gives away or transfers real property, such as a home, buildings or land; or business or personal property, such as money, a bank account, a motor vehicle, a boat, a trust fund, etc.
15. Anyone's physical or mental illness begins or ends.
16. Anyone's citizenship or immigration status changes or anyone gets a letter, form or new card from the INS.
17. Anyone getting cash aid or Medi-Cal/State CMSP becomes pregnant, gives birth, or ends a pregnancy.
18. Anyone goes to or gets out of jail/prison.
19. Any changes in the order for court ordered child support paid by a household member for a child not living in the home (food stamps and Medi-Cal/State CMSP only).
20. Anyone's health care coverage/insurance changes or becomes available as a result of employment (cash aid and Medi-Cal/State CMSP).

For Medi-Cal/State CMSP, you must report when:

21. Anyone enters or leaves a nursing home or long term care facility.
22. Anyone applies for disability benefits, such as SSI/SSP, Social Security, Veterans, or Railroad Retirement.
23. Anyone gets health care services that result from an accident or injury due to someone else's action or failure to act.

YOUR REPORTING RESPONSIBILITIES (CONTINUED)

For Cash Aid and Food Stamps Monthly and Nonmonthly Reporting, you must report when:

24. Any member of your household is hiding or running from the law for a felony, or attempted felony, or is violating their parole or probation.
25. Any member of your household has been convicted of a drug related felony for possession, use or distribution of illegal drugs since August 22, 1996 for food stamps, or if convicted since January 1, 1998 for cash aid.

For Food Stamp Monthly Reporting, you may report when:

26. A household member is age 60 or older.
27. Any member who is disabled or age 60 or older has changes in or new medical expenses. If verified, your allotment can be refigured.

For Food Stamp Nonmonthly Reporting, you must report when:

28. Your total monthly income starts, stops, or changes by more than $25.
29. Anyone's source of income changes.
30. Anyone moves into or out of your home.
31. Anyone joins or leaves your household.
32. You move or you get a new address.
33. Your rent and utility costs **only** if you move.
34. Anyone buys, gets, sells, or gives away a licensed motor vehicle.
35. The total of your household's stocks, bonds, or other money is or is more than $2000 (or $3000 if you have a household member who is age 60 or older).

For Food Stamp Nonmonthly Reporting, you may report when:

36. Anyone's physical or mental illness begins or ends.
37. Anyone's citizenship/immigration status changes or anyone gets a letter, form or new card from the INS.
38. You have changes in your dependent care costs.
39. Any member who is disabled or age 60 or older has changes in or new medical expenses. If verified, your allotment can be refigured.

IMPORTANT INFORMATION CASH-AID ONLY

Unemployed Parent

If you are applying for cash aid as an unemployed parent, the principal earner (PE) must:

- be unemployed and not have worked in the preceding 4 weeks
- apply for and accept any unemployment insurance you are eligible to receive

The PE is the parent who has the most earnings in the past 24 months.

Homeless Assistance

You may be eligible for money to help pay for temporary shelter or permanent housing. This is a once-in-a-lifetime payment unless you meet an exemption. If you have already received homeless assistance and need it again, your worker will tell you if you are eligible.

School Attendance and Immunizations

You must provide proof when requested by the county that:

- all school-age children are attending school, and
- children under the age of 6 have received age appropriate immunizations.

Maximum Aid Payment (MAP)

There are two levels of Maximum Aid Payment (MAP). Most families getting cash aid get the lower MAP level. Families may get the higher MAP level if each parent or caretaker in the Assistance Unit (AU):

- is caring for an aided child(ren) who is not their child and the parent/caretaker does not get aid
- is disabled and getting Supplemental Security Income/ State Supplemental Payments (SSI/SSP), or In-Home Supportive Services (IHSS), or State Disability Insurance (SDI), or Temporary Workers Compensation (TWC), or Temporary Disability Indemnity (TDI) benefits.

Also eligible for the higher MAP:

- a family who gets Refugee Cash Assistance (RCA) if each adult meets an exception.

If all the adults in the household meet at least one of these exemptions, ask your worker about applying for an exemption.

Treatment of Self-Employment

If you are self-employed, you will have a choice of figuring your business expenses based on a standard deduction of 40 percent of gross income or using actual business expenses. Once you choose a method of figuring your self-employed net income, you can only change that way of figuring expenses at redetermination or every six months whichever happens sooner.

Maximum Family Grant (MFG) Rule

The MFG rule applies to any child born after August 31, 1997. The MFG rule says that your maximum aid payment (MAP) will not go up to include a child born to your family, if your family got cash aid for the 10 months in a row right before the child's birth. There are exemptions to the rule. Ask your worker if you have any questions about the MFG rule.

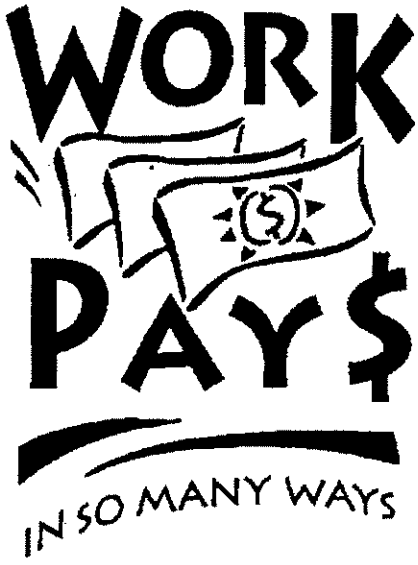
Proof of Facts

If you ask for cash aid within one year of the date it stopped, the county must look at your prior case file to see if it already has the proof needed to determine your eligibility when:

- you cannot get the proof, or
- there is a cost to you to get the proof, or
- processing your application would be delayed because it would take too long for you to get the proof.

If you ask for cash aid within one year of the date it stopped AND, if the county doesn't have the proof it needs, then you will have to provide proof.

If you have new changes since you last got cash aid, the county will need new proof.



You can work and still get cash aid.

Working:

- **gives you more $$$$ to help support your family**
- **builds a better life for you and your family**
- **develops job skills**
- **builds self-esteem**
- **gives you personal satisfaction**

Here's how "Work Pays":

When you work, your gross earnings (earnings before deductions) are not subtracted dollar for dollar from your cash aid payment. You are eligible for work-related deductions.

You may be eligible for child care costs to be paid to your provider.

See page 6 for facts about work and training rules, work incentives, including child care programs.

When you add the amount of your earnings to the amount of your cash aid, you will have more $$$$ for your family.

It always pays to work. You can work and still get cash aid as long as you remain eligible and meet reporting rules in a timely manner.

Ask your worker for more facts about "Work Pays."

Remember, when you don't work, the most $$$$ you can get is the maximum aid payment for your family size.

Cash Aid and Food Stamps Work and Training Rules

After looking at your facts, your worker will tell you what cash aid and/or food stamp work rules you need to follow before and after your application is approved. You may be required to be in work, training or education activities through the Food Stamp Employment and Training (FSET) Program for food stamps, or the Welfare to Work Program for cash aid.

- some **cash aid** clients will be told how to register with the Employment Development Department (EDD).
- more than one member of a household can be required to follow cash and/or food stamp work rules.

If you are registered for work, the rules say you must:

- keep appointments made by your worker
- go to training or education programs when we tell you to
- do job search when we tell you to
- check on possible jobs when we tell you about them
- take a suitable job if it is offered to you.

And for food stamps you must also:

- answer questions about your job experience and ability to work.

Penalties

If you must register for work you can be **disqualified** from getting **cash aid and/or food stamps** if:

- you don't follow the work and training rules and don't have a good reason; or
- you quit a job; or
- for **cash aid** you reduce your earnings; or
- for **food stamps** you reduce your work hours to less than 30 hours per week.

Your **food stamps** can be stopped or denied for:

- One month or until you do what you should do, whichever is longer, for the first violation;
- Three months or until you do what you should do, whichever is longer, for the second violation;
- Six months or until you do what you should do, whichever is longer, for the third or additional violation.

Your **cash aid** can be stopped:

- Until you do what you should do for the first violation;
- For three months or until you do what you should do, whichever is longer, for the second violation;
- For six months or until you do what you should do, whichever is longer, for the third or additional violation.

If anyone is disqualified for not following work or training rules, other members of their household can still get cash aid or food stamps, as long as they remain eligible. But the amount of cash aid or food stamps they get may change.

Cash Aid Only

Welfare to Work Activities

You will need to take part in certain Welfare to Work activities to keep getting your cash aid. The county will tell you how many hours a week you must take part in these activities or if you are exempt from these rules.

Welfare to Work activities include subsidized or unsubsidized work, work experience, community service, adult basic education, vocational training, and job search. Subsidized means that the county or some other funding source pays your employer for part of your wages.

Community Service Activities

After getting cash aid for a certain number of months, you must have a job with a minimum number of hours per week. If you don't, you can only keep getting cash aid if you take part in community service activities. The county will tell you what time limit applies to you and when your time limit starts. There are exceptions to this time limit and the limit does not apply to children.

Income Disregards

When you have income and are on cash aid, there are two income disregards (deductions) that may be subtracted from certain types of family income. When you or any of your family members receive certain types of disability-based unearned income or you are working and getting cash aid, you are eligible for an income disregard of $225. The $225 is first deducted from certain disability-based unearned income. Any remainder of the $225 is then deducted from earned income. If there is a remainder of earned income, 50 percent of that remaining earned income will be disregarded.

CalWORKs Child Care Program

Child care benefits are available to recipients who need child care to work or participate in county-approved welfare-to-work activities such as attending education or job training programs.

California Department of Education (CDE) Child Care

Child care benefits are also available from CDE. Contact your local Resource and Referral Agency for more information.

Transitional Medi-Cal (TMC)

You may get Medi-Cal for up to 12 months if you go off cash aid because you are working. Your family must have gotten cash aid for at least three of the last six months before cash aid stopped. To get more than six months of TMC, your income must be under certain limits and you must meet TMC reporting rules.

OTHER IMPORTANT INFORMATION

CASH AID AND FOOD STAMP MONTHLY REPORTING HOUSEHOLDS

Budgeting Rules

The amount of cash aid or food stamps you can get depends on your income and allowable expenses. What you report on the Monthly Eligibility Report will be used to figure the amount of cash aid and/or food stamps you can get two months later. For example, your income and allowable expenses from January that you report in February are used to figure the cash aid and/or food stamp benefits you would get in March. This method is called retrospective budgeting.

Property Limit

There is a $2000.00 limit on the amount of property (e.g., bank accounts, stocks, etc.) that your household can have and still get cash aid or food stamps. If someone in your household is at least 60 years old, the limit goes up to $3000.00. Your house and furniture are not part of the total limit as long as you live in your home. The individual vehicle value limit is $4650. If you have only one vehicle which is registered, and it has a value of less than $4650, it will not be counted as part of the limit. If your vehicle is worth more than $4650, anything over the limit will be used as part of the total property limit to determine eligibility, unless the vehicle is needed by the household for certain reasons. Your worker can tell you what these are. If you have a vehicle that is unregistered, its value will be figured differently and your worker can explain to you how it is done.

CASH AID ONLY

60-Month Time Limit

As of January 1, 1998, a parent or caretaker relative is not eligible for cash aid when he/she has received cash aid for a total of 60 months. All aid received through CalWORKs (California Work Opportunity and Responsibility to Kids) and/or cash aid received from any other state counts toward the 60-month total. Only cash aid received on or after January 1, 1998, counts toward the 60-month total. There are exceptions to this time limit and the limit does not apply to children.

Transfer of Assets Rule

Recipients can sell, exchange or change the form of their property holdings, if they get fair market value for the property (asset). If they do not get fair market value for the asset, the family will get a period of ineligibility. The period of ineligibility is figured by subtracting the amount received from the fair market value of the asset and then dividing that amount by the need standard for the family. The amount is rounded down to the next lower whole number.

Cal-Learn

Cal-Learn helps pregnant and/or parenting teens under the age of 20, who are getting cash aid and do not have a high school diploma or its equivalent to stay in or return to school. Teens in the Cal-Learn Program may get cash bonuses for good grades and graduation from high school. Cal-Learn teens may get help with child care, transportation, and other services. Cash penalties may be subtracted from their family's cash aid payment for not going to school or for getting poor grades.

FOOD STAMP ONLY

Standard Utility Allowance (SUA)

If you are billed for heating and/or cooling costs that are not included in your rent or mortgage payment, you may be eligible for the Standard Utility Allowance (SUA). The SUA is one deduction for **all** of your eligible utility costs. If your utility bills are more than the SUA, you may switch between actual and the SUA at recertification. If you have other utility costs but your heating or cooling costs are included in your rent, your benefits will be figured on your actual utility costs. Ask the county to check your facts to see if you are eligible for the SUA.

MEDI-CAL/STATE CMSP ONLY

Spending Down Excess Property

- If you get or apply for Medi-Cal/State CMSP Only and you have more property than the rules allow, you may lower it by the last day of any month, including the month of application. For Medi-Cal you may spend your excess property in any manner you want. But you may not be eligible for nursing facility level of care for a period of time if you sell or give away any property for less than its worth, and you apply for or receive Medi-Cal nursing facility level of care within 30 months of the transfer.
- You may not be eligible for State CMSP if you sell or give away any property for less than it is worth.

Resources And Property

- All Medi-Cal benefits received after age 55 are subject to recovery from a deceased Medi-Cal recipient's estate. However, recovery may not exceed the value of the estate. Recovery may not occur if the beneficiary is survived by a spouse. The state may not claim the proportionate share of an estate left to a minor child or a totally disabled adult child. In addition if recovery would cause an undue hardship for any other heirs and that hardship can be demonstrated, recovery may be waived in full or in part.
- If you are institutionalized and your home or former home is not exempt, the State may record a lien against your property to repay the cost of medical care covered by Medi-Cal.

AVAILABLE SERVICES

Women, Infants and Children (WIC) Supplemental Nutrition Program

The WIC Program is only for pregnant and breast feeding women, infants and children under age 5, who are at medical-nutritional risk. For more facts about WIC, call your local county health department or the phone number for "WIC" in the telephone book.

Voter Registration

If you want to register to vote, ask your worker to send you a registration form. If you need help filling it out, ask your worker. You can mail the form yourself. Your eligibility for aid will not be affected whether or not you register. Your worker will not tell you how to vote.

PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting benefits, you can be legally prosecuted, and can be charged with committing a felony if more than $400 is wrongly paid out for cash aid, food stamps, or Medi-Cal because you did not report all of your facts or changes in income, property, or family status. And you can be disqualified from getting cash aid or food stamps.

Disqualification Penalties

Cash Aid and Food Stamps

Disqualification penalties start after a state hearing or court of law finds that the individual has committed an Intentional Program Violation (IPV). Also, anyone who is accused of committing an IPV may agree to be disqualified by signing an Administrative Disqualification Consent Agreement or an Disqualification Hearing Waiver. Anyone who signs one of these documents gives up any hearing rights and accepts responsibility to repay any cash aid overpayment and/or food stamp overissuance.

Cash Aid Penalties

If you do not follow cash aid rules, you may be fined up to $10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, your cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

Food Stamp Only

If your household receives food stamps, it must follow these rules:

- **Don't give wrong or incomplete facts to get or keep getting food stamps.**
- **Don't trade or sell food stamps, Authorization Documents (ADs), or issuance cards.**
- **Don't alter ADs or issuance cards to get food stamps you are not entitled to get.**
- **Don't use food stamps to buy ineligible items such as alcoholic drinks or tobacco, paper, or cleaning products.**
- **Don't use someone else's food stamps, ADs, or issuance cards for your household.**

Food Stamps Penalties

If you do not follow food stamp rules, your food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And you may be fined up to $250,000 and/or sent to jail/prison for 20 years. If you are found guilty in any court of law because:

- **you traded or sold food stamps for firearms, ammunition, or explosives, your food stamps can be stopped forever for the first violation;**
- **you traded or sold food stamps for controlled substance, your food stamps can be stopped for 24 months for the first violation and forever for the second;**
- **you traded or sold food stamps that were worth $500 or more, your food stamps can be stopped forever;**
- **you filed two or more applications for food stamps at the same time and gave the county false identity or residence information, your food stamps can be stopped for 10 years.**

APPLICANT/RECIPIENT CERTIFICATION

- I understand my rights and responsibilities and agree to comply with my responsibilities.
- I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect my eligibility or benefit level for cash aid or food stamps, and/or my Medi-Cal/State CMSP share of cost.
- I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (SAWS 2A).
- I also certify that, if I applied for or get cash aid, I got a copy of the following:
  - ☐ GAIN Program Notice and Exemption (GAIN 53)
  - ☐ Welfare to Work Informing Notice (WTW 5)

  _____
  (APPLICANT/RECIPIENT'S INITIALS)
- I also certify that if I applied for Medi-Cal/State CMSP, I got a copy of the MC 219 and its contents were explained to me.

ELIGIBILITY WORKER'S CERTIFICATION

I certify that the applicant/recipient appears to understand:

- his/her rights and responsibilities and
- the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect his/her eligibility or benefit level for cash aid or food stamps, and/or share of cost for Medi-Cal/State CMSP

I also certify that the applicant/recipient was given a copy of:

- The Rights, Responsibilities, and Other Important Information (SAWS 2A)
- For cash aid:
  - ☐ GAIN Program Notice and Exemption (GAIN 53)
  - ☐ Welfare to Work Informing Notice (WTW 5)
- For Medi-Cal/State CMSP: the MC 219 and that its contents were explained to him/her.

Signature (Parent or Caretaker Relative, Food Stamp Household Member or Authorized Representative, Medi-Cal/State CMSP Applicant/Beneficiary)		Date
Signature (Other Parent Living in the Home)	Witness, if You Signed With An "X"	Date
Eligibility Worker's Signature	Eligibility Worker's Number	Date

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

STATEMENT OF FACTS FOR CASH AID, FOOD STAMPS AND MEDI-CAL/ STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (CMSP)

WORK PAY$

- Fill in the answers to all questions about the benefit(s) you are asking for. Print all answers in ink. The "CA" for Cash Aid, "FS" for Food Stamps and "MC" for Medi-Cal/State CMSP listed to the left of each question tell you which questions are for each program.
- Give any proof (such as bills, receipts and records) to support your answers. Tell your worker when you need help in getting proof or in filling out this form. If you need more space, attach another sheet.
- If you are asking for Food Stamps and you are not an adult member of the household, attach a written authorization signed by the head of household or other adult member.

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER | DATE RCD

CA FS MC (1) **A. Name of person applying, or caretaker relative of child(ren) for whom aid is wanted.** | HOME PHONE ( )

HOME ADDRESS (NUMBER, STREET) | MAILING ADDRESS (IF DIFFERENT) | DAYTIME PHONE ( )

CITY | STATE | ZIP CODE | CITY | STATE | ZIP CODE

☐ New ☐ Restoration
☐ Redetermine ☐ Recertification
☐ Residency Verified
☐ FS ID
☐ FS Aged/Disabled Verified
☐ MC ID
☐ MC Minor Consent: Exempt from ID, Residency, SSN, Verifs

FS **B. Are you homeless?** ☐ YES ☐ NO If "YES": Are you temporarily staying in someone else's home? If "YES": List date you began staying at this home: ☐ YES ☐ NO

(2) **For each ADULT living in the home, give us all the facts. If you are a non-citizen applying for Medi-Cal and you are not (a) LPR (an alien who is a lawful permanent resident of the U.S.), (b) an amnesty alien with a valid and current I-688, or (c) PRUCOL (an alien permanently residing in the U.S. under color of law), do not fill in the shaded box for "Birthplace."**

CA FS MC (A) APPLICANT/NAME (FIRST, MIDDLE, LAST)

CITIZEN/NON-CITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Asylee ☐ Refugee ☐ PRUCOL ☐ Amnesty Alien with I-688 ☐ LPR ☐ Other Lawful Non-Citizen ☐ Undocumented Sponsored? ☐ YES ☐ NO

☐ AU ☐ NON-AU ☐ MFBU
FS Non-HH/Excluded Member Code:

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE / / | SOCIAL SECURITY NUMBER — —

Work Registration/Exemption Codes:
WELFARE TO WORK | FS | ABAWDS

SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO | BIRTHPLACE CITY STATE COUNTRY

VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Non-Citizen ☐ SAVE
DATE OF ENTRY IN THE U.S.

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal ☐ State CMSP

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed

CA FS MC (B) ADULT'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NON-CITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Asylee ☐ Refugee ☐ PRUCOL ☐ Amnesty Alien with I-688 ☐ LPR ☐ Other Lawful Non-Citizen ☐ Undocumented Sponsored? ☐ YES ☐ NO

☐ AU ☐ NON-AU ☐ MFBU
FS Non-HH/Excluded Member Code:

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE / / | SOCIAL SECURITY NUMBER — —

Work Registration/Exemption Codes:
WELFARE TO WORK | FS | ABAWDS

SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO | BIRTHPLACE CITY STATE COUNTRY

VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Non-Citizen ☐ SAVE
DATE OF ENTRY IN THE U.S.

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal ☐ State CMSP

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed

CA FS MC (C) ADULT'S NAME (FIRST, MIDDLE, LAST)

CITIZEN/NON-CITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Asylee ☐ Refugee ☐ PRUCOL ☐ Amnesty Alien with I-688 ☐ LPR ☐ Other Lawful Non-Citizen ☐ Undocumented Sponsored? ☐ YES ☐ NO

☐ AU ☐ NON-AU ☐ MFBU
FS Non-HH/Excluded Member Code:

RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE / / | SOCIAL SECURITY NUMBER — —

Work Registration/Exemption Codes:
WELFARE TO WORK | FS | ABAWDS

SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO | BIRTHPLACE CITY STATE COUNTRY

VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Non-Citizen ☐ SAVE
DATE OF ENTRY IN THE U.S.

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal ☐ State CMSP

MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed

COUNTY USE ONLY

FS NON-HH/EXCLUDED MEMBER (63-402)

1. Separate HH (Purchase/prepare) (.12, .13)
2. Separate HH (Elderly/disabled) (.17)
3. Roomer (must be listed in (13)) (.211)
4. Live-in attendant (.212)
5. Other shared living quarters (.213)
6. Ineligible alien (.221)
7. Boarder (must be listed in (13)) (.3)
8. SSN disqualified (.222)
9. IPV disqualified (.223)
10. Workfare sanctioned (.225)
11. SSI/SSP recipient (.226)
12. Ineligible student (.227)
13. Work req. disqualified (.228)
14. Questionable Citizenship (403.31)
15. Vol. quit ineligible (408.1, .2)
16. Ineligible/disqualified ABAWD (410.4)
17. Fleeing felon/parole or probation violator (.224)
18. Drug felon (.229)

FS WORK/TRAINING EXEMPTIONS (63-407.21)

a. Under 16/60 or older
a.(1) 16/17 not head of household; or 16/17 in school/training at least 1/2 time
b. Mentally/physically unfit for work
c. Mandatory participant in GAIN or Welfare to Work activities
d. Cares for child under 6 or incapacitated person
e. Applicant for/recipient of UIB
f. Participant in drug/alcohol program
g. 30 hour week/min. x 30
h. 1/2 time student in school, training or higher education.

FS ABAWD EXEMPTIONS (63-410.3)

1. ABAWD with FS Work/Training Exemption Code 63-407.21 b, c, d, e, f, or h (.31)
2. Under 18/50 or older (.321)
3. Pregnant (.322)
4. Adult living in HH with dep. child (.323)
5. Lives in ABAWD exempt area (.33)

WORK EXEMPTIONS (42-789 THRU 42-799)

01 Age under 16
02 School Attendance
03 Disability
04 Age 60 or older
05 Care of Another Individual in household
06 Care of Child Age 6 months or under
07 Pregnancy
08 Nonparent relative caretaker (limited)

(3) For each CHILD living in the home, child out of the home for a short time, or child you claim as a tax dependent, give us all the facts. If you are a non-citizen applying for Medi-Cal and you are not (a) LPR (an alien who is a lawful permanent resident of the U.S.), (b) an amnesty alien with a valid and current I-688, or (c) PRUCOL (an alien permanently residing in the U.S. under color of law), do not fill in the shaded box for "Birthplace." If you are pregnant, list child as "unborn" and give due date.

COUNTY USE ONLY

CA FS MC (A) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

PREGNANT ☐ YES ☐ NO

BIRTHDATE OR DUE DATE / /

BLIND, DEAF OR DISABLED ☐ YES ☐ NO

CITIZEN/NON-CITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Asylee ☐ Refugee ☐ PRUCOL ☐ LPR ☐ Other Lawful Non-Citizen ☐ Undocumented ☐ Amnesty Alien with I-688 Sponsored? ☐ YES ☐ NO

CHILD(REN) NEED AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal

MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

FATHER'S NAME

AU (✓)	NON-AU (✓)	MFBU (✓)	FS Non-HH/Excluded Member Code
			☐ MC: not in home, 18-21 & tax dep.

☐ CA 2.1/CA 371 Date of Entry in U.S.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN ☐ Blind/Deaf/Disabled ☐ DED Packet ☐ SAVE ☐ Citizen ☐ Eligible Non-Citizen

CA FS MC (B) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

PREGNANT ☐ YES ☐ NO

BIRTHDATE OR DUE DATE / /

BLIND, DEAF OR DISABLED ☐ YES ☐ NO

CITIZEN/NON-CITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Asylee ☐ Refugee ☐ PRUCOL ☐ LPR ☐ Other Lawful Non-Citizen ☐ Undocumented ☐ Amnesty Alien with I-688 Sponsored? ☐ YES ☐ NO

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal

MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

FATHER'S NAME

AU (✓)	NON-AU (✓)	MFBU (✓)	FS Non-HH/Excluded Member Code
			☐ MC: not in home, 18-21 & tax dep.

☐ CA 2.1/CA 371 Date of Entry in U.S.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN ☐ Blind/Deaf/Disabled ☐ DED Packet ☐ SAVE ☐ Citizen ☐ Eligible Non-Citizen

CA FS MC (C) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

PREGNANT ☐ YES ☐ NO

BIRTHDATE OR DUE DATE / /

BLIND, DEAF OR DISABLED ☐ YES ☐ NO

CITIZEN/NON-CITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Asylee ☐ Refugee ☐ PRUCOL ☐ LPR ☐ Other Lawful Non-Citizen ☐ Undocumented ☐ Amnesty Alien with I-688 Sponsored? ☐ YES ☐ NO

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal

MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

FATHER'S NAME

AU (✓)	NON-AU (✓)	MFBU (✓)	FS Non-HH/Excluded Member Code
			☐ MC: not in home, 18-21 & tax dep.

☐ CA 2.1/CA 371 Date of Entry in U.S.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN ☐ Blind/Deaf/Disabled ☐ DED Packet ☐ SAVE ☐ Citizen ☐ Eligible Non-Citizen

CA FS MC (D) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

PREGNANT ☐ YES ☐ NO

BIRTHDATE OR DUE DATE / /

BLIND, DEAF OR DISABLED ☐ YES ☐ NO

CITIZEN/NON-CITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Asylee ☐ Refugee ☐ PRUCOL ☐ LPR ☐ Other Lawful Non-Citizen ☐ Undocumented ☐ Amnesty Alien with I-688 Sponsored? ☐ YES ☐ NO

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal

MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

FATHER'S NAME

AU (✓)	NON-AU (✓)	MFBU (✓)	FS Non-HH/Excluded Member Code
			☐ MC: not in home, 18-21 & tax dep.

☐ CA 2.1/CA 371 Date of Entry in U.S.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN ☐ Blind/Deaf/Disabled ☐ DED Packet ☐ SAVE ☐ Citizen ☐ Eligible Non-Citizen

CA FS MC (E) CHILD'S NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER — —

SEX (✓) ☐ M ☐ F

BIRTHPLACE (CITY/STATE/COUNTRY)

PREGNANT ☐ YES ☐ NO

BIRTHDATE OR DUE DATE / /

BLIND, DEAF OR DISABLED ☐ YES ☐ NO

CITIZEN/NON-CITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Asylee ☐ Refugee ☐ PRUCOL ☐ LPR ☐ Other Lawful Non-Citizen ☐ Undocumented ☐ Amnesty Alien with I-688 Sponsored? ☐ YES ☐ NO

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal

MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE

IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO

FATHER'S NAME

AU (✓)	NON-AU (✓)	MFBU (✓)	FS Non-HH/Excluded Member Code
			☐ MC: not in home, 18-21 & tax dep.

☐ CA 2.1/CA 371 Date of Entry in U.S.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN ☐ Blind/Deaf/Disabled ☐ DED Packet ☐ SAVE ☐ Citizen ☐ Eligible Non-Citizen

CA MC (4) Does the other parent(s) of the child(ren) or unborn live with you? ☐ YES ☐ NO

If "NO", explain below:

NAME OF PARENT	GIVE THE REASON THE PARENT DOES NOT LIVE IN THE HOME

CA FS MC (5) **Has anyone changed citizenship/immigration status in the last 12 months?** ☐ YES ☐ NO

If "YES", complete below:

NAME	WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)

COUNTY USE ONLY

☐ Verif. on File
☐ CA 64
☐ MC 13

CA FS (6) **A. Is a foster child living in the home?** ☐ YES ☐ NO

If "YES", who:

FS **B. Do you want the foster child(ren) and foster care income counted on the Food Stamp Case?** ☐ YES ☐ NO

☐ CA and FC Elig/CR Chooses:
Child ☐ CA ☐ FC
CR: ☐ CA ☐ None

CA FS MC (7) **Has anyone ever used any other name (maiden, adoptive, etc.)?** ☐ YES ☐ NO

If "YES", complete below:

NAME	OTHER NAME(S) USED
NAME	OTHER NAME(S) USED

		YES	NO
CA MC (8)	**A. Does everyone live in California?** If "NO", explain:		
	B. Does everyone plan to stay in California permanently? If "NO", explain:		
	C. Does anyone own, lease or maintain a home outside California? If "YES", explain:		
	D. Is anyone currently getting public assistance outside California? If "YES", explain:		
	E. Is anyone planning to leave California for more than 30 days? If "YES", explain:		
	F. Did any family member enter the U.S. on a border crossing card or visa? If "YES", explain:		

☐ YES ☐ NO

Calif. Resident:

☐ Property

☐ PA

☐ Border Crossing Card
☐ Visa

MC (9) **Are you or any family member claimed as a deduction for income tax purposes by a person who does not live with you?** ☐ YES ☐ NO

If "YES", who:

WHO CLAIMS FAMILY MEMBER	ADDRESS	RELATIONSHIP
WHO CLAIMS FAMILY MEMBER	ADDRESS	RELATIONSHIP

☐ Tax Dependent Letter Sent
☐ CA 2.1

CA FS MC (10) **A. Has anyone's cash aid, food stamps or Medi-Cal been stopped due to: non-cooperation during a quality control review, work or training sanctions or failure to meet the Food Stamp Able Bodied Adults Without Dependent (ABAWD) work requirement, or for any other reason?** ☐ YES ☐ NO

If "YES", explain below:

NAME	WHY	WHEN	WHAT COUNTY/STATE

CA FS **B. Has anyone's cash aid or food stamps been stopped for a period of time, or forever due to welfare fraud or an Intentional Program Violation?** ☐ YES ☐ NO

If "YES", explain below:

NAME	WHY	WHEN	WHAT COUNTY/STATE

FS (11) **Does anyone living with you buy food and fix meals separately from others in the home?** ☐ YES ☐ NO

If "YES", explain who:

Separate household eligible: ☐ YES ☐ NO

FS (12) **Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability?** ☐ YES ☐ NO

If "YES", explain who:

Separate household eligible: ☐ YES ☐ NO

FS (13) A. Do you pay someone else for meals and/or a room? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON YOU PAY	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
	☐ Meals ☐ Room ☐ Both	$		

CA FS MC B. Does anyone pay you for meals and/or a room? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON WHO PAYS YOU	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
	☐ Meals ☐ Room ☐ Both	$		

COUNTY USE ONLY

Household Elects		ROOMER
BOARDER	HH MEMBER	

FS (14) Does anyone get food from any of the following programs? ☐ YES ☐ NO
- Communal dining facility for the elderly or disabled
- Food distribution program operated by a Native American reservation
- Other food program

NAME	NAME OF PROGRAM	WHO	NAME OF PROGRAM

CA FS MC (15) A. Does anyone live in any of the following: ☐ YES ☐ NO
If "YES", complete below:
- shelter, center
- reservation for Native Americans
- psychiatric hospital/mental institution
- group living arrangement for the disabled/blind
- hospital or nursing home
- subsidized housing for the elderly
- drug or alcohol rehabilitation center
- board and care home
- penal institution/correctional facility

NAME	NAME OF CENTER, SHELTER, HOSPITAL, ETC.	DATE ENTERED	DATE EXPECTED TO LEAVE

FS Eligible Institution: ☐ YES ☐ NO

CA Eligible: ☐ YES ☐ NO

MC B. Does the person who is in a hospital or nursing home have a spouse or minor child at home? ☐ YES ☐ NO

CA (16) Is every child age 6 to 16 attending school regularly? ☐ YES ☐ NO
If "NO", give the name(s) and explain why he/she is not attending regularly.

School Attendence Verified: ☐ YES ☐ NO

CA FS MC (17) A. Is anyone age 16 or older enrolled in school, college, or a training program, or for Medi-Cal include child(ren) ages 14 and 15? ☐ YES ☐ NO If "YES", complete below:

NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM ENROLLED CHECK (✓) ☐ Full time ☐ Half time ☐ Other (specify):	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING ☐ YES ☐ NO

School Enrollment Verif.: ☐ YES ☐ NO
Date Verified:
FS Eligible Student ☐ YES ☐ NO

School Enrollment Verif.: ☐ YES ☐ NO
Date Verified:
FS Eligible Student ☐ YES ☐ NO

CA FS MC B. Complete below for anyone enrolled in college or attending a similar educational institution.

TERM ☐ Semester ☐ Year ☐ Quarter	TUITION/FEES PER TERM $	BOOKS, EQUIPMENT, ETC., PER TERM $
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED
TRANSPORTATION COST PER WEEK $	AMOUNT PAID BY CAR POOL MEMBERS $	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY $

Expenses Verified: ☐ YES ☐ NO
Date Verified:
Financial Aid: ☐ YES ☐ NO
☐ MC 210 S-E

CA (18) A. Is anyone under age 20 and pregnant or a parent? ☐ YES ☐ NO
If "YES", complete below:

NAME	AGE	CHECK (✓) STATUS ☐ Pregnant ☐ Teen Parent

SCHOOL STATUS, CHECK (✓)
☐ Has a High School Diploma ☐ Has a GED ☐ Not Attending School (explain):
☐ Currently Attending School ☐ Other (explain):

B. Has anyone received a cash bonus or penalty, or help with child care, transportation etc. from the Cal-Learn Program? ☐ YES ☐ NO
If "YES", complete below:

NAME	WHERE (COUNTY)	DATE(S) RECEIVED

Referrred to:
☐ Cal-Learn
☐ CA 25
☐ CA 25A
☐ Referred to Welfare-to-Work

CA FS MC (19) Is anyone on strike? ☐ YES ☐ NO
If "YES", complete below:

NAME OF STRIKER	NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM
NAME OF UNION	
DATE WENT ON STRIKE	GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE

Striker Regs Apply:
☐ CA ☐ FS ☐ MC

(20) Has anyone, including children, worked or does any expect to go to work, including part-time and occasional work: Check (✔) "YES" or "NO" for each item.

	YES	NO
Has anyone stopped or refused work or training within the last 60 days?		
Is anyone working or in training now?		
Does anyone expect to be working or in training in the next two months?		

If self-employed: **For Food Stamps and Medi-Cal:** list your business expenses on a separate sheet of paper. **For cash aid:** Do you want your business expenses figured on: check (✔) ☐ 40% standard deduction ☐ your actual business expenses? **If actual**, you must list your business expenses on a separate sheet of paper. If "YES" to above questions, complete below:

(A) NAME	NUMBER OF DAYS AND HOURS OF WORK/TRAINING PER MONTH LAST MONTH_____ THIS MONTH_____	EMPLOYER NAME AND ADDRESS

PAY DATE(S)	SELF-EMPLOYED ☐ YES ☐ NO	WAGES BEFORE DEDUCTIONS $ per	LAST CHECK RECEIVED (DATE)	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS ☐ YES ☐ NO IF "YES", COMPLETE BELOW
LAST DAY OF WORK/TRAINING	OCCUPATION			AMOUNT RECEIVED $_____ AMOUNT EXPECTED $_____
AMOUNT EXPECTED BEFORE DEDUCTIONS $	CHECK EXPECTED (DATE)	REASON FOR LEAVING JOB/TRAINING		

(B) NAME	NUMBER OF DAYS AND HOURS OF WORK/TRAINING PER MONTH LAST MONTH_____ THIS MONTH_____	EMPLOYER NAME AND ADDRESS

PAY DATE(S)	SELF-EMPLOYED ☐ YES ☐ NO	WAGES BEFORE DEDUCTIONS $ per	LAST CHECK RECEIVED (DATE)	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS ☐ YES ☐ NO IF "YES", COMPLETE BELOW
LAST DAY OF WORK/TRAINING	OCCUPATION			AMOUNT RECEIVED $_____ AMOUNT EXPECTED $_____
AMOUNT EXPECTED BEFORE DEDUCTIONS $	CHECK EXPECTED (DATE)	REASON FOR LEAVING JOB/TRAINING		

CA FS MC (21) A. Does anyone pay for care of a child, disabled adult, or other dependent so he/she can go to work, school, or look for a job? ☐ YES ☐ NO
If "YES", complete below and (✔) if for work or training.

WHO GETS CARE	WHO PAYS	WHO GIVES CARE	☐ WORK ☐ TRAINING	AMOUNT/WHEN $ EVERY
WHO GETS CARE	WHO PAYS	WHO GIVES CARE	☐ WORK ☐ TRAINING	AMOUNT/WHEN $ EVERY

CA FS MC B. Does anyone else pay all or part of your child care costs? ☐ YES ☐ NO
Include costs paid by a relative or friend not living in the home, Department of Education, Block Grant, etc. If "YES", complete below:

NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID $	WHO ELSE PAYS	MONTHLY AMOUNT PAID $
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID $	WHO ELSE PAYS	MONTHLY AMOUNT PAID $

FS MC (22) Does anyone pay child or spousal support? ☐ YES ☐ NO
If "YES", complete below:

WHO PAYS	FOR WHOM	AMOUNT PER MONTH $

CA FS MC (23) Has anyone applied for or received unemployment or disability insurance benefits in the last 12 months? ☐ YES ☐ NO
If "YES", complete below:

NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED
NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED

CA (24) Has anyone received a D iversion payment or services from the county? If "YES", complete below: ☐ YES ☐ NO

NAME OF PERSON	NAME OF COUNTY	AMOUNT RECEIVED	LIST SERVICES RECEIVED	ESTIMATED VALUE OF SERVICES	DATE RECEIVED

COUNTY USE ONLY

(A) (✔) if exempt			FS S/E Farmer
CA	MC	☐ FS Adult ☐ FS Child	☐ Yes ☐ No

(B) (✔) if exempt			FS S/E Farmer
CA	MC	☐ FS Adult ☐ FS Child	☐ Yes ☐ No

☐ Verif(s) on file for: ☐ (A) ☐ (B)

FS Vol. Quit or Refusal
PWR Determines as ☐ (A) ☐ (B)
Work history last 120 days ☐ (A) ☐ (B)

(A)	YES	NO
Empl. Statement		
Good Cause Determ		
Voluntary Quit		

(A) ☐ CA: 4 Weeks ☐ FS: 60 days ☐ MC: 30 days
(B) ☐ CA: 4 weeks ☐ FS: 60 days ☐ MC: 30 days

(B)	YES	NO
Empl. Statement		
Good Cause Determ		
Voluntary Quit		

CA: S/E Client Chooses:

(A)	(B)
☐ Actual	☐ Actual
☐ 40% deduction	☐ 40% deduction
☐ Annualize	☐ Annualize

Child Care Informing:
☐ Trustline Informing (CCP 2)
☐ Health & Safety Certification (CCP 5)
☐ Dependent Care Verified

DEP. CARE ELIGIBLE	YES	NO
FS:		
MC:		

Is there another person in household who could provide care? ☐ YES ☐ NO

If Yes, who: _____

Court Order on File ☐ YES ☐ NO
Amount Ordered:
$

Employment History

CA FS MC (25) **Has any parent living in the home worked or been in training in the past 24 months.** ☐ YES ☐ NO

If "YES", complete below:

- Include all work done outside the U.S.
- Include work done in exchange for something besides money, such as rent, food, utilities or **anything else.**
- Begin with each person's most recent job or training.

A. NAME | IS HE/SHE A NATIVE AMERICAN? ☐ YES ☐ NO | IF "YES", LIST TRIBE:

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	4. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
2. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	5. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
3. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	6. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly

B. NAME | IS HE/SHE A NATIVE AMERICAN? ☐ YES ☐ NO | IF "YES", LIST TRIBE:

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	4. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
2. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	5. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
3. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	6. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly

FS (26) **Are all member of the Food Stamp household citizens of the United States (U.S.)?** ☐ YES ☐ NO

If "NO", complete below for each Food Stamp household member who is **not a citizen of the U.S.**

Name of Each Non-Citizen	A. How many years total has this person, their spouse, and/or their parents (before this person was 18 years old) lived in the U.S.?	B. While living in the U.S., in how many of the years reported in A did this person their spouse, and/or their parents (before this person was 18 years old) earn money by working in the U.S.?	C. While living outside the U.S., how many total years did this person, their spouse, and/or their parents (before this person was 18 years old) work in the U.S?
1.			
2.			
3.			
4.			

CA FS MC (27) **Has anyone been in the U.S. military service or the spouse, parent, or child of a person who has been in the military service?** If "YES", complete below: ☐ YES ☐ NO

NAME	U.S. CITIZEN	(✓) STATUS	BRANCH OF SERVICE	DATES OF SERVICE	HONORABLE DISCHARGE
	☐ YES ☐ NO	☐ ACTIVE DUTY MILITARY/VETERAN ☐ SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN			☐ YES ☐ NO
	☐ YES ☐ NO	☐ ACTIVE DUTY MILITARY/VETERAN ☐ SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN			☐ YES ☐ NO

COUNTY USE ONLY

PRINCIPAL EARNER (PE) *	DATE OF APPLICATION	QUARTER OF APPLICATION

*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.

COUNTY USE ONLY

PE/UIB Requirements
Earnings from month prior to month of application
App Date: ______
Earnings from ______ *to* ______

MO/YR	(25) A	(25) B
	$	$
TOTAL	$	$

	(25) A	B
Tribal JOBS Referral		
UIB Verif(s) on file		
Must apply for		
Currently Receiving/Gov/ or UIB eligible in last 12 months		

Ineligible Reason

(26)
FS: ☐ *40 Quarters Verif.*

(27)
☐ *CA 5*
FS: Non-Citizen's Honorable Discharge Verif.
☐ *YES* ☐ *NO*

CA FS MC (28) **A. Does anyone, including children, get or expect to get money from any source listed below?** Check (✔) YES or NO for each item.

	YES	NO		YES	NO
Training			Strike benefits		
Work Study, JTPA, GAIN, or other program			Service Connected Benefits, Military allotment or pension		
Other training allowance			Veterans Administration		
Educational grants, loans and scholarships			Aid & Attendence		
Welfare			Disability		
CalWORKs			Educational related		
Refugee Assistance			Railroad Retirement		
GA/GR (General Assistance/Relief)			Disability		
State Benefits			Retirement		
UIB (Unemployment Insurance)			Other federal, state, or local government agency		
DIB/SDI (State Disability)			Disability		
Workers Compensation			Retirement		
Support			Other pension, sick leave or disability		
Child/spousal			Native American per capita payments		
(Money for) Medical bills or premiums			Winnings (gambling/lottery/bingo, prizes, etc.)		
Social Security Benefits			Sale of notes, contracts, trust deeds, promissory notes		
Disability or SSI			Other (Explain)		
Retirement or survivors					
Loans, gifts, contributions					
Legal or Insurance settlements/ court actions pending					

COUNTY USE ONLY

- ☐ Casualty Unit Notified
- ☐ CWC 6041
- ☐ DHS 6155
- ☐ Verif(s) on File

Explain Anticip. Income

Workers Comp: ☐ Temporary ☐ Permanent

If "YES", complete below:

NAME	SOURCE	AMOUNT (BEFORE DEDUCTIONS)	WHEN	HOW OFTEN
		$		
		$		

(✔) if exempt

CA	FS	MC

CA FS MC **B. Does anyone expect a change in the amount of money received now, such as a cost-of-living raise?** ☐ YES ☐ NO

If "YES", complete below:

NAME	WHAT	AMOUNT	WHEN
		$	

CA FS MC (29) **Does anyone get housing or rent, utilities, food or clothing free or in exchange for work?** ☐ YES ☐ NO

If "YES", complete below and check (✔) if free or in exchange:

ITEM RECEIVED	Free	Exchange	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM
Housing or rent				$	
Utilities				$	
Food				$	
Clothing				$	

In-Kind Income:

Verif. on file: ☐ YES ☐ NO

Partial	Full	
	Earned	Unearned

CA FS MC (30) **A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.?** ☐ YES ☐ NO

If "YES", complete below. Include land and/or buildings in which the title is shared.

TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✔)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME
	LIVE IN IT					$	$
Listed for sale ☐ YES ☐ NO	RENTAL PROPERTY						
	OTHER (EXPLAIN):						

Home Exempt ☐ YES ☐ NO

Other Real Property

Market Value $

Amount Owed $

Net Value $

Lien Applicable

☐ Listed for sale ☐ YES ☐ NO

TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✔)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME
	LIVE IN IT					$	$
Listed for sale ☐ YES ☐ NO	RENTAL PROPERTY						
	OTHER (EXPLAIN):						

Home Exempt ☐ YES ☐ NO

Other Real Property

Market Value $

Amount Owed $

Net Value $

Lien Applicable

☐ Listed for sale ☐ YES ☐ NO

CA MC **B. Does anyone own a house that is not lived in now that he/she hopes to return to someday?** ☐ YES ☐ NO

If "YES", complete below:

OWNER OF PROPERTY	PROPERTY ADDRESS	EXPECTED DATE OF RETURN (IF KNOWN)

Total Countable property: Page 7 (List totals on page 9)

CA/FS $

MC $

CA FS MC (31) **A. Does anyone, including children, have any of the following personal or business related resources?** Check (✔) each item either "YES" or "NO".
Include all resources owned, used, controlled, shared or held jointly with any person(s) (even for convenience only). The county will determine whether or not these resources count.

	YES	NO		YES	NO
Cash (on hand or elsewhere)			Income tax refund		
Uncashed checks (on hand or elsewhere)			Native American or other trust funds (whether or not available)		
Savings accounts - children's and adult's			Notes, mortgages, deeds of trust, contracts of sale, etc.		
Checking accounts - whether or not they are used			IRA or Keogh plans, etc.		
Credit union accounts			Retirement funds which are available if you stop work (such as PERS, etc.)		
Stocks, bonds, certificates of deposit, money market accounts, etc.			Employee deferred compensation plans		
Oil, mining, or mineral rights			Life insurance or annuity		
Burial trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items			Life estate interest in any property		
			Long term care insurance		
			Other (explain)		

IF "YES", COMPLETE BELOW:

RESOURCE	BUSINESS RELATED	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE
	☐ YES ☐ NO				$
	☐ YES ☐ NO				$
	☐ YES ☐ NO				$

CA FS MC **B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.?** ☐ YES ☐ NO
If "YES", complete below:

NAME	SOURCE OF MONEY	AMOUNT	HOW OFTEN	BUSINESS RELATED
		$		☐ YES ☐ NO
		$		☐ YES ☐ NO

MC (32) **Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services?** ☐ YES ☐ NO
If "YES", complete below:

LIEN OR SECURED AMOUNT	TYPE AND LOCATION OF PROPERTY	DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED	NAME OF PROVIDER
$			
$			

CA FS MC (33) **A.** Does anyone own any personal property, such as: ☐ YES ☐ NO
- boats, 3-wheelers, off-road vehicles, snowmobiles, mobile homes, campers, or trailers.
- guns; tools; or sporting equipment, etc.
- pets or livestock.
- jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).

If "YES", complete below: Do not include wedding and engagement rings or heirlooms.
For cash aid and food stamps: list items worth more than $100; **for Medi-Cal:** list jewelry worth more than $100 and household goods or personal items worth more than $500 per item.

ITEM (✔) IF LISTED FOR SALE	DATE BOUGHT	PURCHASE PRICE/ OR CURRENT VALUE	AMOUNT OWED	ITEM (✔) IF LISTED FOR SALE	DATE BOUGHT	PURCHASE PRICE/ OR CURRENT VALUE	AMOUNT OWED
☐		$	$	☐		$	$
☐		$	$	☐		$	$

B. Does anyone have any business property, including tools, inventory and materials, business equipment, etc. Include any property that is shared or held jointly with any other person(s)? If "YES", complete below and (✔) if listed for sale: ☐ YES ☐ NO

ITEM	DATE BOUGHT	PURCHASE PRICE/ OR CURRENT VALUE	AMOUNT OWED	ITEM	DATE BOUGHT	PURCHASE PRICE/ OR CURRENT VALUE	AMOUNT OWED
☐		$	$	☐		$	$
☐		$	$	☐		$	$

COUNTY USE ONLY

☐ Trust Fund/Not Court Ordered
☐ Court Petitioned
Date _____
☐ Resource Verified:
Explain how:

Total Value = _____

☐ Burial Reserve or Trust (MCO)
Amount Owed $_____
☐ Revocable
☐ Irrevocable
☐ Designated Fund and Current Value
$_____

☐ CA Restricted Account

Check (✔) if exempt

CA	FS	MC

Verified: ☐ YES ☐ NO

Lien Applicable: ☐ YES ☐ NO
Security Agreement: ☐ YES ☐ NO

MC 174 completed and sent: ☐ YES ☐ NO

☐ Owned Jointly
☐ Owned Separately

☐ Personal Property $500 + for Pickle Program

☐ Listed for sale
(Specify):

Total Countable property: Page 8
(List totals on page 9)
CA/FS $ _____
MC $ _____
☐ Listed for sale
(Specify):

CA FS MC (34) **A. Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else?** (List any property sold or traded within the last 12 months for cash aid and within the last 2 1/2 years (30 months) for Medi-Cal). If "YES", explain what and when: ☐ YES ☐ NO

MC **B. Has anyone received money from insurance or court settlements, inheritance, lottery or back pay in the last 2 1/2 years (30 months)?** If "YES", complete below: ☐ YES ☐ NO

NAME	SOURCE	DATE RECEIVED	AMOUNT
			$

CA FS MC (35) **Does anyone own, have the use of or have their name on the registration of any motor vehicle, e.g., mobile home, camper, snowmobile or boat, even if not running?** If "YES", complete below. Look at your registration to get facts for each vehicle: ☐ YES ☐ NO

	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
OWNER OF VEHICLE						
NAME OF PERSON WHO USES VEHICLE						
YEAR/MAKE/MODEL						
LICENSE NUMBER						
ESTIMATED VALUE	$		$		$	
BALANCE OWED	$		$		$	
LICENSED	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO
LEASED	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO
HOW DO YOU USE THE VEHICLE? Check (✔) each item YES OR NO	YES	NO	YES	NO	YES	NO
As a Home						
To go to work or training or for job search						
For work, self-support, or self-employment						
Needed for disabled household member						
To get household's fuel or water						

COUNTY USE ONLY

Closed Bank Accts:
- ☐ CA in last 12 months
- ☐ Medi-Cal in last 30 months

☐ Adequate Consideration
☐ Spenddown

LTC ONLY
Total Nonexempt Property
$ _____

Compute Vehicle Valuation in Section Below:
- ☐ MC: Use Pickle Handbook
- ☐ Verifications viewed
- ☐ Leased vehicle: ☐ (1) ☐ (2) ☐ (3)

Vehicle value
(Enter Date of blue book issue or other documentation)

(1) Date:_____ $_____

(2) Date:_____ $_____

(3) Date:_____ $_____

COUNTY USE ONLY - VEHICLES

CASH AID/FOOD STAMPS	VEHICLE (1)	VEHICLE (2)	VEHICLE (3)
(A) Is vehicle a home, income producing, primary transportation to get fuel/water, or used for a disabled household member? (63-501.521)	☐ YES (Exclude) ☐ NO Go to B	☐ YES (Exclude) ☐ NO Go to B	☐ YES (Exclude) ☐ NO Go to B
(B) 1. Is vehicle for home use? (Allow one vehicle only) OR 2. Is vehicle used for job search, employment or training? (63-501.523)	☐ YES ☐ NO Go to C and D. Use Greater Value ☐ YES Go to C Use Excess Value	☐ YES ☐ NO Go to C and D. Use Greater Value ☐ YES Go to C Use Excess Value	☐ YES ☐ NO Go to C and D. Use Greater Value ☐ YES Go to C Use Excess Value

(C) Fair Market Values-CA/FS

FMV			
Minus $	Minus $	Minus $	Minus $
Excess Value			

(D) Equity Values-CA/FS

FMV			
Minus Encumbrance			
Equity Value			

MEDI-CAL

	(1)	(2)	(3)
DMV/YR/Class Code	_____	_____	$ _____
Vehicle Market Value	$ _____	$ _____	$ _____
Less Encumbrances	$ _____	$ _____	$ _____
Net Value	$ _____	$ _____	$ _____
Exempt	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Pickle Program:			
Is RV used primarily as a home?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

TOTALS: VEHICLE CA/FS
Excess Value $ _____
Equity Value $ _____

Grand Total Countable property
(List totals from pages 7, 8, and 9)

Page	CA/FS	MC
(9)	$ _____	$ _____
(8)	$ _____	$ _____
(7)	$ _____	$ _____
Total	$ _____	$ _____

CA FS MC (36) **A. Does anyone have any housing costs?** ☐ YES ☐ NO
If "YES", complete below:

HOUSING COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Rent	$	$	$	
House (mortgage) payment	$	$	$	
Property taxes (if not in house payment)	$	$	$	
Insurance (if not in house payment)	$	$	$	
Other (explain)	$	$	$	

CA FS MC **B. Does anyone else pay all or part of these housing costs? Include a relative or friend not living in the home, any rental assistance programs, such as HUD, Section 8, etc.** If "YES", complete below: ☐ YES ☐ NO

TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH	HOW OFTEN BILLED
		$	
		$	

COUNTY USE ONLY

Housing verified: ☐ YES ☐ NO

Total housing $ _____

Shared housing: ☐ YES ☐ NO

FS (37) **A. Does anyone have any utility costs?** ☐ YES ☐ NO
If "YES", complete below:

UTILITY COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Gas or other fuel	$	$	$	
Electricity or other fuel	$	$	$	
Is the gas or electricity or other fuel used to heat or cool your house?	☐ YES ☐ NO			
Water	$	$	$	
Sewage	$	$	$	
Garbage or trash	$	$	$	
Telephone (Basic rate for one phone plus tax)	$	$	$	
Installation of utilities	$	$	$	
Other (explain)	$	$	$	

FS **B. Does anyone else pay all or part of these utility costs? Include a relative/friend not living in the home, Low Income Energy Assistance, etc.** If "YES", complete below: ☐ YES ☐ NO

TYPE OF UTILITY COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED

Utilities verified: ☐ YES ☐ NO

Metered: ☐ YES ☐ NO

Client elects
☐ Actual
If Actual, Total Utilities
$_____

☐ SUA
SUA prorated:
☐ YES ☐ NO

FS (38) **You can authorize someone else in your household or someone outside your household to pick up your food stamps or to use them to buy food for you. If you would like to authorize someone, complete below:**

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		( )

☐ F.S. I.D. Issued

CA MC (39) Did anyone get medical/pregnancy treatment this month or in the three months before this month? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDI-CAL FOR THOSE MONTHS?	
		YES	NO	YES	NO

CA FS MC (40) Does anyone have MEDICARE coverage? ☐ YES ☐ NO
If "YES", complete below:

PERSON COVERED	MEDICARE CLAIM NUMBER	Check (✔)	MONTHLY PREMIUM DEDUCTED FROM CHECK	MONTHLY PREMIUM PAID BY YOU
		Part A ☐ Part B ☐	☐ YES ☐ NO	☐ YES ☐ NO
		Part A ☐ Part B ☐	☐ YES ☐ NO	☐ YES ☐ NO

CA MC (41) Does anyone have health, dental, vision, hospitalization or Long Term Care insurance or health plans such as Kaiser, Blue Cross, CHAMPUS, etc.? ☐ YES ☐ NO
If "YES", complete below:

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			$	
			$	

CA MC (42) Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for? ☐ YES ☐ NO
If "YES", complete below:

INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID
		$	
		$	

CA MC (43) Is anyone's health insurance expected to end or has it ended within the last 60 days? ☐ YES ☐ NO
If "YES", complete below:

INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
			$	
			$	

CA MC (44) Does anyone have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON	TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

CA FS (45) A. Does anyone have a medical condition(s) or situation(s) that requires any of the following?
Check (✔) each item YES or NO:

	YES	NO		YES	NO
Special diet—prescribed by a doctor			Very high use of utilities		
Special transportation need			Special laundry service		
Special telephone or other equipment			Other (specify):		
Housework (no one in the home can do it)					

If "YES", explain:

CA MC FS B. Is there a child or disabled person in the household who needs care from another household member? ☐ YES ☐ NO
If "YES", explain:

CA MC C. Is anyone a disabled person who is working and who has medical expenses, (wheelchair, etc.), which are needed for the person to be able to work? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON	TYPE OF EXPENSE	AMOUNT
		$
		$

CA FS D. Is anyone getting In-Home Supportive Services (IHSS)? ☐ YES ☐ NO
If "YES", who gets service? **How much do you pay each month? $**_____

COUNTY USE ONLY

Retroactive Application
- ☐ Retro Only
- ☐ Retro and Cont.
- ☐ MC 210A

- ☐ MEDICARE referral

FS: ☐ DFA 285-C
Gross Premium $ _____
- ☐ QMB
- ☐ SLMB
- ☐ QDWI

State Certified LTC Policy: ☐ YES ☐ NO
- ☐ DHS 6155

Benefits Paid Out $_____

- ☐ DHS 6155

- ☐ DHS 6155

- ☐ Third Party Liability

Verified: ☐ YES ☐ NO
Special Need: ☐ YES ☐ NO
Amount : $_____

- ☐ Receipts
- ☐ MC 272 ☐ MC 273

- ☐ IRWE (QMB and SGA)

FS: ☐ DFA 285-C

CA (46) Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and unusual circumstances, such as an earthquake, fire or flood? ☐ YES ☐ NO
If "YES", explain below.

COUNTY USE ONLY

	YES	NO
Special Need Verified	☐	☐
Eligible for Special Need	☐	☐

CA FS (47) A. Is anyone hiding or running from the law for a felony, attempted felony, or a parole or probation violation? If "YES", give name of the person: ☐ YES ☐ NO

CA FS B. Has any member of the household been convicted of a drug related felony for possession, use, or distribution of illegal drugs since August 22, 1996, for Food Stamps or January 1, 1998, for cash aid? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED

CA MC (48) The following services are available. Your answers to these questions will not affect your eligibility. Check (✓) each item YES or NO.

	YES	NO	
A. Regular check-ups and immunizations to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.			☐ CHDP Brochure and Explanation Given Date: _____ ☐ Referral
• Do you want more information about CHDP Services?			
• Do you want more information about immunization services?			☐ Social Services Referral (MCO)
• Do you want CHDP medical services?			
• Do you want CHDP dental services?			
• Do you need help making appointments or with transportation to CHDP services?			
B. If you are pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?			☐ Pregnant ☐ Parent or Guardian of child under 5
C. Are you breastfeeding a child?			☐ Breastfeeding ☐ Postpartum
If YES, have you given birth within the last 12 months?			
If you checked "YES" to (48) B, C, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).			☐ WIC referral
D. Do you or any family member want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.			☐ Family Planning Information Given ☐ Referred Date:

CERTIFICATION

I understand that the disqualification and/or welfare fraud penalties I will get if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

I understand that:

- I must apply for and keep any available health coverage if no cost is involved; if I don't my Medi-Cal will be denied or stopped.
- If I do not follow cash aid rules, I may be fined up to $10,000 and/or sent to jail/prison for 3 years.
- If I am found guilty by a court of law or an administrative hearing of committing certain types of fraud, my cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.
- If I do not follow food stamp rules, my food stamps will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to $250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
  - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation.
  - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second;
  - I traded or sold food stamps that were worth $500 or more, my food stamps can be stopped forever;
  - I filed two or more applications for food stamps at the same time and gave the county false identity or residence information, my food stamps can be stopped for 10 years.

I also understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc.
- All facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident alien (LPR), (b) an amnesty alien with a valid and current I-688, or (c) an alien permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the INS.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a non-citizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law for a felony or attempted felony, or is in violation of their parole or probation cannot get cash aid/or food stamps.
- Anyone who has been convicted of a drug related felony for possession, use, or distribution of illegal drugs since August 22, 1996, cannot get food stamps or if convicted since January 1, 1998, cannot get cash aid.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)	DATE

SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

COUNTY USE ONLY

	REGULATIONS MET?							REGULATIONS MET?						FOOD STAMP TESTS			
	CA		FS		MC			CA		FS		MC			YES	NO	NA
	YES	NO	YES	NO	YES	NO								Categorically Eligible			
Residency							Property—Within limits and verified amount $							Gross Income Test Household Size Gross Monthly Income $			
Deprivation																	
Age							Work registration/ FSET/ABAWDs							Gross Income Eligible			
Citizen/Eligible non-citizen							Sponsored alien							Separate HH Income Test Household Size Gross Monthly Income $			
School enrollment							Federal participation established (If "NO", explain)							Eligible for Separate HH Status			
Pregnancy verified/WIC Referral							Referred for Health Care Options (HCO) Presentation (Managed Care)							Aged/Disabled			
SSN														DFA 285-C			
Income—Gross and net income														If "NO", why:			

AU Size:	Non-AU Size:	AU/MFBU Size:
☐ INELIGIBLE (REASON)		
☐ ELIGIBLE ☐ DIVERSION ☐ REDETERMINATION ☐ MAP EXEMPTION		AUTHORIZATION DATE
ELIGIBILITY CONDITIONS MET (DATE):		EFFECTIVE DATE
ELIGIBILITY WORKER'S SIGNATURE		DATE
SUPERVISOR'S SIGNATURE (COUNTY OPTION)		DATE

FS:	HH Size:
☐ INELIGIBLE (REASON)	
☐ ELIGIBLE ☐ RECERTIFICATION	AUTHORIZATION DATE
ELIGIBILITY WORKER'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE (COUNTY OPTION)	DATE

CALWORKS - REDUCED INCOME SUPPLEMENTAL PAYMENT REQUEST

YOU MAY GET EXTRA MONEY IF THE COUNTY IS COUNTING INCOME AGAINST YOUR CASH AID AND THAT INCOME HAS DROPPED OR STOPPED.

- You must use this form to ask for the extra money.
- You can only get extra money if your income dropped or stopped and **not** for other reasons such as **birth of a child**, **clothing** needs for children returning to school, or you need to **move**.
- You must apply in the month that you need the extra money, not before or after.
- You must complete and return a separate form during each month that the county is counting income that has dropped or stopped against your Cash Aid.
- If you get extra money, your food stamp benefits may be affected.

The county must determine your eligibility for extra money within 7 working days after the date this completed form is received. If you don't need the form this month, keep it for later.

Questions? Ask your worker.

Worker Name: Phone:

1. Complete the following:

CASE NAME	YOUR SOCIAL SECURITY NUMBER

2. Explain about the income that dropped or stopped. Complete below:

What Income Changed?	When?	Why Did It Change?

3. Attach proof of the change in income (Job Termination Notice, SSA/DIB/UIB Notices, Statements, etc.) If you have no proof, list the employer or agency that can be contacted:

EMPLOYER/AGENCY	PHONE

ADDRESS

4. Apply only in the month that income dropped or stopped, not the month before or after. This money is for the month of_____. List expected income and source of income for that month: *(Do not list your grant amount)*

• INCOME	• SOURCE OF INCOME
Gross Earnings $	
Other Income $	

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification including contacting the above named person, employer or agency.
- I further declare under penalty of perjury under the laws of the United States of America and the State of California that the statements I have given on this form are true and correct to the best of my knowledge.
- I authorize the county to obtain any verification of income and circumstances necessary to process this request. This authorization is valid for 30 days from the date signed.

SIGNATURE	DATE SIGNED
SIGNATURE OF SPOUSE OR OTHER ADULT RECIPIENT	DATE SIGNED
PHONE	MESSAGE PHONE

On this form, disclosure of your Social Security Number (SSN) is voluntary. The SSN will be used to identify you and your records. If we cannot identify you, you may not get any extra money.

COUNTY USE ONLY

DATE POSTMARKED SUPPLEMENTAL MONTH

CASE NUMBER/WORKER NAME/NUMBER

A. ACTUAL GRANT AMOUNT (RISP Month) $

B. RISP MONTH ESTIMATED NET INCOME

1. Total Disability-Based Unearned Income of AU + Non-AU Members $
2. $225 Disregard -
3. Subtotal Nonexempt Disability Based Income (A1 minus A2) (If positive enter amount in B9) (If negative enter amount in B5) =
4. Gross Earned Income (AU + Non-AU) $
5. Remainder of $225 Income Disregard (Enter amount from line B3 if negative) -
6. Subtotal Earned Income (B4 minus B5) =
7. 50% Earned Income Disregard (B6 divided by 2) -
8. Subtotal (B6 minus B7) (Net Nonexempt Earned Income) =
9. Nonexempt Unearned Disability Based Income (Enter amount from line B3 if positive) +
10. Other Countable Income of Family
    _____ +
    _____ +
11. Net Nonexempt Income of Family (Sum total of B8, B9 and B10) $

C. RISP MONTH AVAILABLE INCOME

1. Actual Grant Amount (Enter from A) $
2. O/P adjustment (if used in actual grant computation) +
3. Special Need (if used in actual grant computation) -
4. Child/Spousal Support Disregard +
5. Net Nonexempt Income (Enter from B11) +
6. Sanctions (Such as 25% Non-Co-op)
   _____ +
   _____ +
7. Total Available Income $

D. RISP PAYMENT

1. 80% of MAP $
2. Total Available Income (Enter from C7) -
3. RISP Payment $

☐ APPROVED ☐ DENIED

EW SIGNATURE DATE

CALWORKS* - SOLICITUD PARA PAGO SUPLEMENTAL DEBIDO A LA DISMINUCION DE INGRESOS

PUEDE RECIBIR DINERO ADICIONAL SI EL CONDADO CONSIDERA SUS INGRESOS PARA DETERMINAR SU ASISTENCIA MONETARIA Y ESOS INGRESOS HAN DISMINUIDO O SE HAN DESCONTINUADO.

- Tiene que usar este formulario para solicitar dinero adicional.
- Solamente puede recibir dinero adicional si sus ingresos han disminuido o se han descontinuado y **no** por otras razones, tales como: **el nacimiento de un bebé**, la necesidad de **ropa** para niños cuando regresan a la escuela, o porque necesita **cambiarse** de casa.
- Tiene que presentar la solicitud el mes en que necesite el dinero adicional; no antes ni después.
- Tiene que completar y devolver un nuevo formulario cada mes en que el condado considere ingresos que han disminuido o se han descontinuado para determinar su asistencia monetaria.
- Si recibe dinero adicional, es posible que sus beneficios de estampillas para comida resulten afectados.

El condado tiene que determinar su elegibilidad para recibir dinero adicional antes de que pasen 7 días laborables después de la fecha en que el condado reciba este formulario completado. Si no necesita el formulario este mes, guárdelo para después.

¿Tiene preguntas? Hágaselas a su trabajador.

Nombre del trabajador: Teléfono:

1. Complete lo siguiente:

NOMBRE DEL CASO	SU NUMERO DEL SEGURO SOCIAL

2. Explique sobre los ingresos que disminuyeron o se descontinuaron. Complete abajo:

¿Qué ingresos cambiaron?	¿Cuándo?	¿Por qué cambiaron?

3. Adjunte pruebas del cambio en los ingresos [notificación de terminación de empleo, notificaciones de la Administración del Seguro Social (SSA)/Beneficios del Seguro contra Incapacidad/Discapacidad (DIB)/Beneficios del Seguro contra Desempleo (UIB), declaraciones, etc.]. Si no tiene pruebas, escriba el nombre del patrón o de la oficina con la que nos podemos comunicar:

PATRON/OFICINA	TELEFONO

DIRECCION

4. Presente la solicitud solamente el mes en que los ingresos disminuyan o se descontinúen; no en el mes antes ni en el mes después. Indique cuánto espera que sean sus ingresos para este mes y la fuente de esos ingresos. Este dinero es para el mes de _____. *(No incluya la cantidad de su pago mensual)*

• INGRESOS	• FUENTE
Ingresos brutos ganados $	
Otros ingresos $	

CERTIFICACION

- Comprendo que las declaraciones que he hecho en este formulario están sujetas a investigación y verificación, incluyendo el comunicarse con la persona, la oficina o el patrón nombrados arriba.
- Adicionalmente declaro, bajo pena de perjurio y en conformidad con las leyes de los Estados Unidos de América y del Estado de California, que las declaraciones que he hecho en este formulario son verdaderas y correctas según mi leal saber y entender.
- A fin de que se tramite esta solicitud, autorizo al condado para que obtenga la verificación que sea necesaria en relación a mis ingresos y las circunstancias en que me encuentro. Esta autorización es válida por 30 días desde la fecha en que la firme.

FIRMA	FECHA EN QUE SE FIRMO
FIRMA DEL ESPOSO(A) O DE OTRO ADULTO QUE RECIBA EL PAGO	FECHA EN QUE SE FIRMO
TELEFONO	TELEFONO PARA MENSAJES

El proporcionar su número del Seguro Social (SSN) en este formulario es voluntario. El SSN se usará para identificarlo a usted y sus expedientes. Si no podemos identificarlo, no podrá recibir dinero adicional.

*CalWORKs: Programa de California de Oportunidades de Trabajo y Responsabilidad hacia los Niños

SOLO PARA USO DEL CONDADO

DATE POSTMARKED | SUPPLEMENTAL MONTH

CASE NUMBER/WORKER NAME/NUMBER

A. ACTUAL GRANT AMOUNT (RISP Month) $

B. RISP MONTH ESTIMATED NET INCOME

1. Total Disability-Based Unearned Income of AU + Non-AU Members $
2. $225 Disregard -
3. Subtotal Nonexempt Disability Based Income (A1 minus A2) (If positive enter amount in B9) (If negative enter amount in B5) =
4. Gross Earned Income (AU + Non-AU) $
5. Remainder of $225 Income Disregard (Enter amount from line B3 if negative) -
6. Subtotal Earned Income (B4 minus B5) =
7. 50% Earned Income Disregard (B6 divided by 2) -
8. Subtotal (B6 minus B7) (Net Nonexempt Earned Income) =
9. Nonexempt Unearned Disability Based Income (Enter amount from line B3 if positive) +
10. Other Countable Income of Family
    _____ +
    _____ +
11. Net Nonexempt Income of Family (Sum total of B8, B9 and B10) $

C. RISP MONTH AVAILABLE INCOME

1. Actual Grant Amount (Enter from A) $
2. O/P adjustment (if used in actual grant computation) +
3. Special Need (if used in actual grant computation) -
4. Child/Spousal Support Disregard +
5. Net Nonexempt Income (Enter from B11) +
6. Sanctions (Such as 25% Non-Co-op)
   _____ +
   _____ +
7. Total Available Income $

D. RISP PAYMENT

1. 80% of MAP $
2. Total Available Income (Enter from C7) -
3. RISP Payment $

☐ APPROVED ☐ DENIED

EW SIGNATURE | DATE